STATE OF NORTH DAKOTA

BOARD OF NURSING

IN THE MATTER OF:	)	
	)	
State of North Dakota and	)	
the Board of Nursing of The	)	**RECOMMENDED**
State of North Dakota,	)	**FINDINGS OF FACT,**
	)	**CONCLUSIONS OF LAW,**
Complainant,	)	**AND ORDER**
	)	
vs.	)	
	)	
Cletis Wigton, R.N.	)	
	)	
Respondent.	)	

. . . . . .

On August 14, 2001, a Complaint was filed with the Board of Nursing of the State of North Dakota ("Board") by Constance B. Kalanek, the Board's Executive Director ("Kalanek"), requesting administrative action against the Registered Nurse ("R.N.") license of Cletis Wigton ("Wigton"), License Registration # 9134, the Respondent in this administrative matter. The Complaint cites as grounds for administrative action violations of N.D.C.C. § 43-12.1-14 and N.D. Admin. Code § 54-02-07-01.1. On August 31, 2001, Wigton filed an Answer. On December 11, 2001, Kalanek filed an Amended Complaint. The Amended Complaint cites as further grounds for administrative action additional violations of N.D.C.C. § 43-12.1-14 and N.D. Admin. Code § 54-02-07-01.1. Wigton did not file an answer to the Amended Complaint because a hearing had already been scheduled, Wigton had agreed to the filing of an Amended Complaint, and Wigton intended to respond at the hearing.

The original Complaint contains four allegations; the Amended Complaint contains twelve allegations. The original four allegations are the core allegations in this administrative matter. The other eight allegations are peripheral.

On September 5, 2001, the Board requested the designation of an administrative law judge (ALJ) from the Office of Administrative Hearings to conduct a hearing and to issue recommended findings of fact and conclusions of law, as well as a recommended order, in regard to the Complaint. On September 10, 2001, the undersigned ALJ was designated.

On September 17, 2001, the ALJ issued a Notice of Prehearing Conference scheduling a September 26 prehearing conference. The prehearing conference was held and a hearing was scheduled. On September 26, 2001, the ALJ issued a Notice of Hearing scheduling a December 4, 2001, hearing. On November 27, 2001, Counsel for the Board filed a Motion in Limine to Limit Testimony and for Sanctions. On November 28, 2001, counsel for the parties and the ALJ held an informal prehearing conference. On November 30, 2001, the ALJ issued a Prehearing Conference Summary and Notice of Rescheduled Hearing. (Sanctions were agreed upon, Wigton agreed to allow the Board to amend the Complaint, and the parties agreed to reschedule the hearing). The hearing was rescheduled for December 20, 2001.

The hearing was held as rescheduled on December 20, in the Fort Union Room, State Capitol, Bismarck, North Dakota. Special Assistant Attorney General Calvin N. Rolfson represented the Board. Wigton was present at the hearing. Donald L. Peterson, Minot, represented Wigton. The hearing was not completed on December 20. On December 27, 2001, the ALJ issued a Notice of Continued Hearing. It scheduled January 15 and 16, 2002, to continue the hearing. The hearing was continued on those two days and completed on January 16. During the course of the hearing the Board called fact six witnesses, all Rock View Good Samaritan Center, Parshall,

North Dakota ("Rock View") employees. *See* Plaintiff's Final Argument at 2-3. The Board also called Kalanek as an expert witness. 31 exhibits (nos. 1-31) were marked for the record. Exhibit 24 was not offered. Exhibits 6 was offered, objected to, and withdrawn. Exhibit 28 was offered but not admitted and withdrawn. Exhibit 30 was offered but not admitted and submitted under an offer of proof (therefore it may only be considered as evidence if a court rules that the ALJ erred in not admitting it). The remainder of the exhibits were admitted, some over objection. Wigton testified in her own behalf but she did not call any other witnesses or offer any exhibits.

There are 14 hearing tapes in this matter; six tapes from the December 20, 2001, hearing; five tapes from the January 15, 2002, continued hearing; and three tapes from the January 16 continued hearing. Most of the tapes are 90-minute tapes.

Counsel agreed to file simultaneous written closing argument (briefs). It was agreed that the briefs would be filed so that they would be in the ALJ's hands no later than January 31, 2002. On January 31, 2002, Counsel for the Board filed Plaintiff's Final Argument. On February 1, 2002, Counsel for the Respondent filed Respondent's Post-Hearing Brief. The Respondent's brief was dated and postmarked January 31, 2002.

The ALJ closely reviewed his hearing notes, many of the hearing tapes and the exhibits from the record in this matter. The evidence shows that the core allegations, the first four allegations of the Amended Complaint, are proven. Of the peripheral allegations, five through twelve, some are proven by the evidence, but most are not, and those that are proven may seem relatively insignificant even though they are proven. Even regarding the core allegations there are some concerns about the evidence and the interpretations that result from the evidence. This is a difficult matter to assess. It seems that after her termination at Rock View, and perhaps

because of it, Wigton's actions and activity came under very close scrutiny. In some cases, it seems, Wigton's actions and activity were put under a microscope.

Based on the evidence presented at the hearing and the briefs of the parties, the administrative law judge makes the following recommended findings of fact and conclusions of law regarding the Amended Complaint.

FINDINGS OF FACT

1. Wigton is a Registered Nurse in the State of North Dakota. The Board licensed her during the time period of the allegations in question in the Amended Complaint, from September to December 2000. She applied for a 2002-2003 Two Year License (Renewal Application) on November 4, 2001. Exhibit 29. It is unclear from the application form whether the renewal license has been granted at this time, however, counsel for the Board asks in the recommendation portion of his brief that Wigton's license be suspended. Plaintiff's Final Argument, at 24. Perhaps it can be assumed that Wigton's application was granted and she has an active license for 2002-2003. However, the Board may take official notice of whether a current grant of license has been made to Wigton. In any event, Wigton's R.N. license during the time period of the allegations, when she was actively licensed, is in question.

2. Wigton is an experienced nurse. She graduated in nursing in 1956. She has worked in many different nursing settings, including clinic, hospital, home health care, geriatric nursing, industrial nursing, psychiatric home visits, and more. She has 15 years of geriatric nursing experience. Wigton has been licensed in and worked in several other states besides North Dakota. Her husband was a flight instructor in the military. She had been a Director of Nursing ("DON") previously and was a DON at the time of the allegations of the Amended Complaint, the DON at

Rock View. Rock View is a nursing care facility under the Good Samaritan Society umbrella. Wigton is not currently employed as a nurse. She now lives in Bismarck.

3. When Wigton came to Rock View on September 5, 2000, hired as DON, she was to be oriented to the facility. A two-day orientation session was scheduled for her beginning on September 20, 2000. Wigton attended the orientation session only from 9:00 a.m. until about 10:15 a.m. on the first day. She was then called out of orientation and did not return. She never completed any more orientation before she was terminated from Rock View on December 5, 2000. *See* exhibit 22 for those portions of the orientation checklist completed by Wigton. The evidence shows that she apparently completed only those orientation topics that were signed by her (the three items at the top of the left hand column under "Orientation Explained" and two other individual items "Workers Comp. Explained" under "Safety" and "Fire Extinguisher Identified" under "Emergency Equipment identified"). Wigton did not even go on a facility tour.

Wigton claims that she was unable to complete orientation because of the demands of the DON position during the whole time she was at Rock View. However, there was insufficient evidence about the true situation regarding Wigton's actual opportunities to attend orientation either for the remaining part of the two day scheduled orientation or later. There was no evidence offered about administration's efforts to orient Wigton in light of the failure of the scheduled two-day orientation session. However, the evidence is that Wigton was not officially excused from orientation. It is Rock View policy that all new employees attend orientation.

Some of the evidence offered tends to show that there was sufficient staff generally available to fill in for Wigton to attend orientation, but there was no evidence about staffing availability to fill in for Wigton on the specific days that her two day orientation was scheduled

to occur and there was no evidence about any attempt to orient Wigton later. Apparently, there was no such attempt.

Neither the business manager nor the administrator specifically requested Wigton to complete orientation (it was the business manager who was the chief witness at the hearing about orientation and she was the person overseeing orientation at the time at Rock View). Rock View's administrator was at that time concurrently sharing the same duties at two facilities. He spent 60% of his time in Parshall and 40% in New Town. The administrator is no longer at Rock View but is administrator at Park River Good Samaritan Center in Park River, North Dakota.

Failure to complete orientation does not excuse any of the allegations of the Amended Complaint, but it may help to explain some of them, as a general if not specific factor.

4. Wigton claims that the conditions at Rock View were "deplorable." She claims that the facility was inadequately staffed, especially in regard to CAN staffing. Wigton also claims that patient charts at Rock View were not in good order and that there were significant inadequacies in patient charting. However, except for some reference to and general description by Wigton about the inadequacies of Rock View and Rock View patient charts, there was no definitive evidence about the adequacy or inadequacy of Rock View or patient charts in any respect. There was only specific evidence about Wigton's own alleged inadequacies. This was not a hearing about the facility, yet it is troubling that there appears this somewhat undefined tone of facility inadequacy and failure, and inadequacy of patient charts. Nevertheless, there is insufficient evidence to state that the inadequacies and failings at Rock View contributed in any meaningful way in regard to any of the allegations of the Amended Complaint.

5. Allegation #1 of the Amended Complaint is the allegation regarding the administration of the Mantoux PPD (TB) test to another Rock View employee, who is also a

registered nurse. *See* Amended Complaint for more specific allegation. Essentially, the evidence proves this allegation. Wigton was helping staff with the administration of Mantoux tests at Rock View. Wigton administered the Mantoux test to a nurse employee. In the administration of the test Wigton failed to follow Rock View policy and procedure (exhibit 1) for Mantoux testing in that Wigton administered the test to the nurse employee who, prior to the test, informed Wigton that she was a positive reactor and allergic to the test. *See* exhibit 1, Procedure 7 (c). Documentation in the employee's file also indicates a history of a positive TB test and an allergy to TB screening. *See* exhibit 2.

However, there are some troubling aspects regarding this allegation. There is the matter of the Employee/Candidate Mantoux Questionnaire form. Exhibit 3. This is a new employee form. It is a questionnaire that was filled out by Wigton and the employee. The employee checked the questionnaire boxes on the left of the form and, then, Wigton completed the remaining portions of the Questionaire, and the employee signed it. However, Wigton signed the consent portion in the upper right hand portion of the questionnaire for the employee, in Wigton's own handwriting, even though the employee was far older than 18 years (the nurse has been licensed as an R.N. for 36 years). Also, the employee was not a new Rock View employee.

On this form (exhibit 3), which was in use by Rock View at the time, the employee did check the box indicating that she had never "had redness, swelling or hardness from a Mantoux shot or skin test on … [her] forearm." The employee also checked the box indicating that she had a previous BCG vaccination (an immunization against TB).

The employee testified that she twice told Wigton that she was a positive reactor to the Mantoux test. Wigton testified that she twice asked the employee whether she was a positive reactor to the test and the employee said no each time. The employee seemed more believable.

However, other than some evidence showing that the employee was somewhat afraid of Wigton, there is really no satisfactory explanation of why the employee would indicate a negative response on the questionnaire and then testify that she told Wigton that she was a positive reactor to the Mantoux test. The employee is originally from the Phillipines but has been in the United States many years. She is a rather soft-spoken individual. The employee did testify that she did not remember reading or signing exhibit 3.

Although no medical charts on the employee were made available to Wigton by the employee or others, neither did Wigton seek out any confirmation about the true situation regarding the employee, in regard to the Mantoux test, before she gave her the vaccination, even though Wigton acknowledged that at the time the situation troubled her somewhat. Curiously, exhibit 3 was not in the employee's file at Rock View but was obtained from Wigton.

Wigton claims that she was following the Center for Disease Control guidelines regarding certain high-risk people being tested for risk of TB, also claiming that the Rock View policy was outdated. However, there was never any effort by Wigton to update the Rock View policy while she was there, and there was no evidence that Rock View followed the CDC guidelines. Rather, Rock View had a clear policy on Mantoux PPD testing. Exhibit 1.

The employee should have been exempt from further TB screening. Wigton should not have given the Mantoux test to the employee. Wigton either knew, or should have suspected and than found out, the true situation with regard to the employee before administering the test.

It is likely that Wigton did not know the Rock View procedure regarding the Mantoux test because she did not complete orientation.

Rather than opt on the side of caution and assess the situation more carefully, Wigton opted to follow through with the test and the employee suffered with an allergic reaction to the

test, including an inflamed and swollen arm for a long period of time, difficulty with breathing for a short while, and other indicators of an allergic reaction.

Kalanek testified that the allergic reaction could have resulted in anaphylactic shock and even death for the employee.

Although Wigton wanted the employee to have a chest x-ray after the Mantoux test, the employee did not have one. The evidence was somewhat confusing about whether the employee was due for a chest x-ray under Rock View policy. The employee did not fill out an incident report in regard to Wigton inappropriately administering a Mantoux test to her.

6. Allegation #2 of the Amended Complaint is the allegation that Wigton falsified facility documents in that she wrote on several patient records using another nurse's initials. This allegation is essentially proven. Wigton admitted that the initials and writing on the "Rehab Treatment Record" of a Rock View resident, at four different places, were hers and not the nurses that they purport to be. Exhibit 5. Wigton wrote entries for another nurse in four locations on the record and then entered the other nurse's initials following the entry (twice in handwriting, twice printed). Wigton did not provide any explanation or correction, or indicate attribution. She also failed to sign her own or the other nurses name at the appropriate spot near the bottom of the entry.

Wigton claims that the other nurse in question had been improperly writing the rehabilitation technician's recommendations as doctor's orders, and that she repeatedly told the nurse to remove the recommendations because they were not doctor's orders. Wigton claims to have written these entries at the recommendation of a Good Samaritan consultant. Wigton said that in writing for the other nurse and signing her initials she made no attempt to deceive or defraud anyone.

The other nurse claims to have taken an order from the PT person, cleared it, and placed it on the resident's original chart. The other nurse testified that Wigton's entry made for her on

the Rehab Treatment Record should not have been placed there, it was improperly located and should have been located on the care plan. The other nurse did not recall that Wigton had expressed to her a concern about improperly writing orders.

Wigton admits that she did not bring her concern to the attention of the other nurse. In fact, the evidence shows that the other nurse was not at the facility when Wigton made the entry for her on the day in question. Wigton admitted that she forgot to put her own initials next to the other nurses.

There seems to be uncertainty in the evidence regarding the reasons for Wigton's actions in making this false writing and the other nurses alleged actions of making improper entries. However, there is no uncertainty about the fact that Wigton wrote for someone else, signed their initials, and made no effort to explain why or to attribute. There is no documentation to justify Wigton's conduct and, really, there is nothing to justify Wigton's conduct.

Kalanek testified that on a permanent record, a nurse must never initial writing by the nurse using only some other nurse's initials as a reference to the author of the writing.

7. Allegation #3 is that Wigton failed to follow facility policy and procedure for patient suicide precautions in that Wigton performed a psychiatric assessment on a resident with incomplete follow through. *See* more specifics in the allegation of Amended Complaint. This allegation is essentially proven.

Exhibit 8 is Rock View's specific procedure regarding "suicide precautions." It is clear that under that document Wigton failed to correctly follow through on the facilities stated procedure.

On November 1, 2000, Wigton made an entry on a resident's inter-disciplinary progress note. Exhibit 7. She relates that the day before the resident stated "he wants to blow his head

off." *Id*. There was absolutely no suicide policy follow through on the resident until several weeks later when the facility social worker discovered the matter in a routine review of charts.

Wigton claims to have completed an incident report that she gave to the administrator, but there is nothing in the record to support that other than her testimony. The administrator denies having received one.

Again, perhaps Wigton did not know about Rock View's suicide precaution procedure because she was not oriented regarding it, but she was an experienced geriatric nurse and claims to have had training, education, and experience in the area of psychiatric nursing. Nurses are trained to document.

Even though Wigton charted an assessment on the resident, there is no documentation of an analysis, intervention, or evaluation in the records. Further, there is no documentation in any physician orders for this resident between October 31, 2000, when Wigton received the verbalized suicide ideation and November 13, 2000, when this patient's physician would have had an opportunity to document this issue had the physician known about it. Exhibit 9. In addition, this patient's geriatric psychiatry report disclosed no statement whatsoever regarding a suicide ideation. Exhibit 10.

Wigton says she did evaluate the risk of self harm for the resident and determined that the statement was simply a statement and that the resident had no ability to carry out a suicide, and she listed her findings in the inter-disciplinary progress notes. Exhibit 7. She also said that she determined that no interventions were necessary and that the resident was not at risk. However, she did not document her evaluation, or a determination that no interventions were necessary, or a determination that the resident was not at risk.

Again, Wigton said that she did fill out an incident report and gave it to the administrator. However, even if Wigton did fill out an incident report and give it to the administrator, and the ALJ is not convinced that she did, she did not follow the suicide procedure of the facility. The incident report regarding a suicide precaution at Rock View is not to go initially to the administrator but to the social worker ("Social Services or other appropriate staff") and the physician, and then, perhaps, to other appropriate staff, such as the administrator. Exhibit 8. Also, there was other documentation required by the suicide precautions document that Wigton did not fill out. Exhibit 8.

Kalanek testified that the assessment phase completed by Wigton was proper but that there was no follow through, *i.e.*, no analysis, intervention, and evaluation. She also said that if no intervention was necessary it should have been documented that that was the case. Also, Kalanek said that appropriate forms need to be used for the required follow through. Wigton having not completed orientation likely did not know that there were other forms to fill out. On the other hand, she did not check to see if there might be other forms to fill out, either.

8. Allegation #4 is that Wigton failed to follow the Rock View policy and procedure regarding facility property and records in that she removed pharmacy tracking forms from Rock View without authorization and permission to do so. Rock View policy is that "[n]o documents, materials relating to facility operations or other facility property may be removed from the facility without approval of the administrator." Exhibit 23, Employee Handbook, at 14. This allegation involves not facility approved forms but documents that were not regularly kept by the facility. Yet, the documents were undisputedly facility documents.

Wigton was asked by the administrator to begin to collect information regarding pharmacy medication errors after Wigton brought the concern to his attention because of a

nurse's complaint. Rock View had a problem in that it was apparently getting incorrect types of medications from the pharmacy. The administrator asked Wigton to began tracking errors in types of medications so that the matter could be discussed with the pharmacist. Wigton began collecting information such as that found in exhibit 25.

Wigton claims that she does not know where the "Pharmacist Med error sheet" form came from. Exhibit 25, pages 1 and 2. The administrator said that it, as well as the other form (page 3 of exhibit 25), was not a facility form. But, Wigton started the process of employees recording pharmacist medication errors on that form. The remaining pages of the tracking document were copies of the labels ('blister packs") made by someone, *i.e.*, copies of the medication labels. In other words, the facility began trying to track medication errors through the rather informal efforts of Wigton, at the direction of the administrator. However, there is no doubt that this was done with documents that were or became facility documents. It was done for a facility purpose.

The administrator testified that Wigton was to keep track of these documents for the investigation (collection of information) regarding this concern over pharmacy medication errors, and the tracking thereof. Wigton testified that she was overseeing this project.

Wigton said she kept these documents in her office and when she was terminated in early December she claims that two maintenance people came to her office to help her move out. She said that they cleaned off her desk and put these tracking documents and other documents in a box. Then, Wigton said, they put the box in her trunk and she eventually removed the boxes to her Brush Lake Cabin where they remained for some time. She says that she did not provide the tracking documents to the facility (actually to Mr. Rolfson) until November 11, 2001, pursuant to a discovery request made by Mr. Rolfson of the Respondent, through her attorney, a request that

required a motion to be filed by Mr. Rolfson. *See* Motion in Limine to Limit Testimony and for Sanctions, dated November 27, 2001.

However, other evidence shows that earlier the administrator tried to get these documents back from Wigton. He said that he did not give approval for the removal of the documents at any time, including at the time of Wigton's termination.

Before Wigton's termination, at a meeting with a Good Samaritan regional director, on November 30, 2000, Wigton was asked about the pharmacy error records and Wigton stated that her lawyer had them and she would return them to the facility. After her termination, the administrator said that he called Wigton and she stated that she gave the documents to her attorney. The administrator said that he then called Wigton's attorney who said that he would see "if [they] had a copy" but that "[h]e will do want (*sic*) cletis (*sic*) says!" Exhibit 26, administrator's note of Peterson telephone conversation.

Clearly, the evidence shows that Wigton still had the documents in her office before she was terminated and she knew that the administrator wanted them. It is believable that they were in her office and, as she said, placed in a box by maintenance people at the time of her termination. However, it is not believable that she was unaware of the fact that the facility considered the documents its documents and they wanted them back as soon as possible. The evidence shows that she knew the facility wanted the documents. Perhaps she did not always know exactly where they were but she knew the facility wanted them. It was inexcusable for Wigton to not return them until November 12, 2001, and then, only at the insistence of counsel for the Board as part of the Board's investigation in this matter and only after she was directed to do so by her attorney. There was some testimony about the original documents, but it was never cleared up about where they might be or who had them, but clearly Wigton had possession of

copies of tracking records that were removed from the facility and she did not return them for some time, even though she knew the facility wanted her copies back. The evidence proves the allegation.

9. Allegation #5 is that Wigton charted that she performed a nursing assessment on a resident when she did not perform the assessment.

On November 5, 2000, another nurse charted that she cleaned a resident's toes, noted an open area, and contacted the physician's assistant. Exhibit 11. On November 6, Wigton charted in regard to the same resident, making an assessment. On November 6, the other nurse charted again and noted that orders were received. On November 8, Wigton again charted and made an assessment and applied bacitracin to the toes in accordance with the orders. The allegation is that Wigton did not do the nursing assessment on November 6 but, rather, she simply entered the assessment without evening assessing the resident. The ALJ believes that the evidence on this is not conclusive. The allegation is not proven. There is not solid evidence that Wigton did not observe the condition she stated in making her assessment. This allegation appears to be a matter of whether to believe one nurse or another. The ALJ is not prepared based on the evidence to say that Wigton was in error on this allegation.

10. Allegation #6 is that Wigton charted that a resident was transported to Trinity Medical Center in Minot for x-rays, when, in fact, the resident was transported to the Medical Arts Clinic in Minot. *See* exhibits 12 and 13.

There was no conclusive proof about where, *i.e.*, to what facility, this resident was actually taken. There seems no doubt that the resident was taken to Minot pursuant to the orders of a physician's assistant (PAC). Exhibit 13. But, even that was in question for a considerable time at the hearing. The entry following Wigton's on the same day by another nurse does

indicate a return of the resident from the Medical Arts Clinic (exhibit 12) (no city stated), however, there was much confusion at the hearing about the sequence of events. There was, at that time, also a branch of the Medical Arts Clinic in Parshall, and the physician's assistant worked for the Parshall branch. There was some testimony that the resident was taken to the Medical Arts Clinic in Parshall and then to Minot. However, all the evidence considered, it appears the resident was not taken to the Parshall Clinic but was taken to Minot for an x-ray. The physician's assistant does make mention of the resident being taken to Minot, but not the facility. Exhibit 13.

Further, it is unclear whether Wigton's entry was documentation of an order or a statement of where the patient was taken. Wigton says that the physician's assistant told her the resident was going to Trinity in Minot and that as far as she knew, the physician assistant always sent residents to Trinity in Minot.

At one point in the hearing, counsel for the Board stated that the Amended Complaint was in error and that it should be amended to read "when in fact the patient was transported to the Medical Arts Clinic in Parshall," (rather than "Medical Arts Clinic in Minot"), but he later recanted that request.

In short, the situation at the time of the actual incident on October 16, 2000, may have been confusing; it was certainly confusing at the hearing. This allegation is not proven.

11. Allegation #7 is that Wigton documented in a resident's medical treatment record that treatments were to be done on the patient when no physician orders existed for such treatment.

Wigton charted in the resident's treatment record and profile (exhibit 14) on October 23, 2000. She documented that this resident's toes were to be cleaned on her right foot three times per week, that ointment was to be placed on the toes, and that the toes were to be cleaned with vinegar water. She

also documented that this resident was ordered to have a "boot" placed on her left foot when up in a chair. Exhibit 14.

Wigton admitted that there were no orders for these procedures, but claimed to have an "understanding" with the physician's assistant, that no orders were needed for what Wigton claimed were "simple procedures." Wigton testimony. Yet, there are no standing orders at Rock View nor are their facility policies permitting such directives. Other Rock View nurses testified as did Kalanek, that this charting involved a medical procedure requiring a physician orders. There were no physician orders in regard to the treatments applied by Wigton. Exhibit 15. Yet, Wigton performed and documented the procedures. This allegation is proven.

12. Allegation #8 is that Wigton inaccurately charted that a resident provided cares for herself when the patient had not cared for herself for many months previously.

Counsel for the Board notes in his brief that this allegation "may be a small matter on its own." The ALJ agrees. Further, although counsel believes that the allegation is proven, the ALJ believes that it is not. When the entry is read in total it is not clear that Wigton is making a statement that the resident cares for herself to an extent that others giving care later are to assume that Wigton made an assessment that the resident cares for herself. In fact, the opposite seems to be true. The entry does not state that the resident cares for herself in every way. It appears that Wigton is noting that the resident stated (and likely believes) that she cares for herself to some extent regarding her colostomy, although Wigton did not put any statement by the resident in quotes. Kalanek testified that this was at the least sloppy record keeping. Perhaps it was at least that but, truly, this is a small matter, taken somewhat out of context.

13. Allegation #9 is that Wigton charted that no new physician orders had been received for a resident when such orders had been documented as received. This allegation was abandoned by counsel for the Board at the hearing. *See* exhibit 17. This allegation is not proven.

14. Allegation #10 is that Wigton inaccurately charted an entry on a resident. *See* exhibit 18. There was testimony that the charting should have been on another resident. The other nurses who testified thought it was clear that Wigton charted the wrong resident. Wigton, however, was adamant that she got the right resident. Other than a belief that Wigton got it wrong, there was really no proof that Wigton was wrong. None of the other nurses were there with Wigton when she noted the behavior, they only looked at Wigton's entry later and concluded that it had to be the wrong resident, that it must have been charting about another resident who they knew by habit does smack her lips continually. However, the resident that Wigton charted on does have a neurological problem and was also noted to be confused. There was little testimony and none conclusive about whether, indeed, the resident Wigton charted on could have been smacking her lips or not on the day in question. The closest testimony to something conclusive was that one witness testified that it was not that resident's habit (the resident Wigton charted on) to smack her lips. The evidence is not conclusive that Wigton was in error. The allegation is not proven.

15. Allegation #11 is that Wigton inaccurately charted that a resident was not a diabetic when in fact the resident had been a diabetic for years. This allegation is proven, though it is troubling to so conclude. This was one of the most difficult, if not the most difficult, of the several allegations to deal with.

On exhibit 19, inter-disciplinary progress notes, on October 3, 2000, Wigton documented, "[r]esident does not have diagnosis of diabetes so insulin administration & … [blood] sugar

monitoring not required." Some other entries or records of this resident however, indicate contrary. On November 1, 2000, Wigton again documented, "Resident is diabetic & bears watching… [each] day." Exhibit 19. These assessments by Wigton are opposite. The physician's orders on this resident in the resident's chart on August 15, 2000, indicate a diagnosis of "diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled." Exhibit 20. The physician's admitting order when this patient was admitted to the facility on May 16, 1998, indicate a diagnosis of diabetes requiring the medication Glipizide. Exhibit 31.

Wigton's explanation is that the resident was new to her and there was no current diabetes medication in place when she made the assessment. She says that she was merely saying that she was not aware of any diagnosis of diabetes. She says that she did not see exhibit 20; it was not in the resident's chart at the time, and she says that she looked. She said that physician orders did not always get into the chart right away at Rock View. Wigton said she wrote what she did even though she did not know for certain whether there was a diagnosis of diabetes because she was always getting questioned on her procedures and she merely wanted to note that there was no diabetes diagnosis for this resident. She said that she later wrote that there was a diabetes diagnosis because she asked a doctor about it and found out there was a diagnosis.

It appears from her testimony that Wigton knew that she needed to ask a doctor about this resident. But if that is her explanation, Wigton failed to follow-up reasonably to determine if the resident had a diagnosis of diabetes. She did not chart a diagnosis of diabetes until one month later.

16. Allegation #12 is that Wigton falsified her application for RN/LPN Renewal to the Nevada State Board of Nursing. *See* Amended Complaint for specifics. Exhibit 28 was offered as evidence but when Wigton's counsel objected to its admission on grounds that the

exhibit was not provided to him prior to the hearing as required, the exhibit was withdrawn. Without it, there is not enough evidence to prove this violation.

CONCLUSIONS OF LAW

1. Wigton is apparently currently licensed as an R.N. in the State of North Dakota by the Board under the provisions of N.D.C.C. ch. 43-12.1 and N.D. Admin. Code Title 54. Wigton was also licensed during the time she was DON at Rock View, from September to December 2000.

2. During the time Wigton was the DON at Rock View she committed the following violations of law. These violations are proven to have occurred by the greater weight of the evidence presented at the hearing.

a. Allegation #1. Wigton failed to follow facility policy and procedure for Mantoux PPD (TB) testing in that she administered a Mantoux test to a nurse employee who, prior to the test, informed Wigton that she was a positive reactor and allergic to the test. Wigton's actions in this regard are in violation of N.D.C.C. § 43-12.1-14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(5) and (6). *See* N.D. Admin. Code § 54-05-02-02.1.

b. Allegation #2. Wigton falsified facility documents in that she wrote on several patient records using another nurse's initials. Wigton's actions in this regard are in violation of N.D.C.C. § 43-12.1-14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(7). *See* N.D. Admin. Code § 54-05-02-02.1.

c. Allegation #3. Wigton failed to follow facility policy and procedure for patient suicide precautions in that she performed a psychiatric assessment on a patient with incomplete follow through. Wigton's actions in this regard are in violation of N.D.C.C. § 43-12.1-14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(5) and (6). *See* N.D. Admin. Code § 54-05-02-02.1.

d. Allegation #4. Wigton failed to follow the facility policy and procedure regarding facility property and records in that she removed pharmacy medication tracking forms from the facility without authorization and permission to do so. Wigton's actions in this regard are in violation of N.D.C.C. § 43-12.1 -14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(5) and (6). *See* N.D. Admin. Code § 54-05-02-02.1.

e. Allegation #7. Wigton documented in a resident's medical treatment record that treatments were to be done on the resident when no physician orders existed for such treatment, in violation of N.D.C.C. § 43-12.1-14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(5) and (6). *See* N.D. Admin. Code § 54-05-02-02.1.

f. Allegation #11. Wigton inaccurately charted that a resident was not a diabetic when in fact the patient had been diabetic for years, in violation of N.D.C.C. § 43-12.1-14(3) and (5), and N.D. Admin. Code § 54-02-07-01.1(5) and (6). *See* N.D. Admin. Code § 54-05-02-02.1.

3. The evidence does not show, by the greater weight of the evidence, that Allegations #s 5, 6, 8, 9, 10, or 12 are proven. Therefore, no violations of N.D.C.C. § 43-12.1-14 or N.D. Admin. Code § 54-02-07-01.1 are shown regarding those allegations.

4. N.D.C.C. § 43-12.1-14 authorizes the Board to deny, limit, revoke, encumber, or suspend any license to practice nursing issued by the Board on grounds of violations of the law listed in N.D.C.C. § 43-12.1-14, or any rules adopted by the Board pursuant to N.D.C.C. § 43-12.1-14.

5. N.D.C.C. § 43-12.1-13 authorizes the Board to impose fees for each separate violation of law, or to impose the assessment of costs and disbursements, or both, against any

respondent in an administrative disciplinary action by the Board against licensure, in addition to the licensing sanction.

COMMENTARY ON LEGAL ANAYSIS

There is mention in the Plaintiff's Final Argument about deference to the Board's ultimate decision in this matter and the Board's interpretation of its own rules. In the Plaintiff's Final Argument and in the presentation of Kalanek as the Board's expert there is, perhaps, an implication that the ALJ is to give deference to the Board's interpretation of its statutes and rules as applicable to facts relating to Wigton in this matter, *i.e.*, deference to Kalanek's interpretation of the statutes and rules for the Board. Certainly, the ALJ must give deference to previous Board decisions on point regarding a matter currently under consideration by him; he must give deference to general clearly articulated Board statements regarding interpretation of its own statutes and rules; and he must give deference to Board interpretation's of its own statutes and rules in previous administrative proceedings as they are indicated to be on point with the facts in this administrative matter. However, counsel for the Board has indicated no previous Board matter that is generally or specifically precedence for the ALJ in this matter.

The ALJ is not required to give deference to interpretations of Board rules made by the Board's experts at a Board hearing, even if that expert is the Board's executive director. The ALJ is the Board's designated hearing officer in this matter. He is presiding for the Board, though not employed by the Board. He issues a recommended decision to the Board in this matter. The Board issues the final decision. The Board has not yet interpreted anything regarding this matter, and, apparently, will not (there were no Board interpretations offered and the ALJ has taken official notice of none) until the Board makes its final decision. In other words, unless there is clear precedent indicated, the ALJ's interpretation of the Board's statutes and rules as applied to

the facts of this case is the Board's interpretation, unless and until the Board rules otherwise in its final decision.

While the expert opinion of Kalanek may be entitled to some weight, perhaps more than it would be entitled to if there had been contrary expert testimony from a Wigton expert, it is not entitled to be given deference by the ALJ. The singular knowledge of Kalanek is not the collective knowledge of the Board.

In fact, the ALJ does give great weight to the testimony of Kalanek in this matter, in light of the facts that he believes are proven from the hearing.

Counsel for the Board cites a New York case regarding an administrative matter as similar to this administrative matter, saying that that court "sustained a nurse's sanction for 'playing games' with patient charts - a theme running through this case." Plaintiff's Final Argument, at 7, citing *In re Civil Serv. Emps. Local v. Tioga County (No. 89654 N.Y. App. Div.), 2001*. The ALJ does not find that Wigton was involved in any kind of games playing in this matter. She appeared at the hearing as a serious, though outspoken and somewhat haughty individual. She did commit the violations indicated, but her situation in the Rock View facility and the facts of this matter appear to be far different than the situation of the nurse and the facts in the New York case. Some of what Wigton did cannot be defended, it is true, but the ALJ does not find her an unsympathetic character in this matter.

RECOMMENDED ORDER

Counsel for the Board, based on the violations he believes are proven, *i.e.*, based on violations alleged 1-8, 10, and 11, asks for certain administrative action against Wigton. In making his recommendations Counsel essentially acknowledges that the evidence offered and admitted did not prove allegations 9 and 12. For these 10 violations Counsel recommends that

Wigton's R.N. license be suspended for three years, that she be required to pay to the Board a penalty fee of $1,000, and that she be required to pay to the Board all lawful costs and disbursements associated with this administrative matter as may be certified by the Board's Executive Director.

However, not 10 violations, but 7 violations were proven at hearing. Even if Wigton had been found to have 10 violations of the law as counsel for the Board concludes, the ALJ would have been hesitant to recommend imposition of a three year suspension against the license of a nurse who after many, many years of, apparently, at least adequate service as a nurse, service without any violations of law being found against her license in any other state or this state, now is found to be in violation of the laws of this state, in the manner indicated in this administrative hearing. In relative terms, *i.e.*, based on the Board's past actions, a lesser sanction and penalty seems warranted. A much lesser sanction and penalty seems warranted with a conclusion of seven violations.

Based on the findings of fact and conclusion made in this matter, and considering that this is a first time violator of the nursing laws in North Dakota, it is ORDERED that Wigton's RN license to practice nursing in North Dakota is SUSPENDED for a period of two years. However, the two-year period of suspension shall not be invoked provided that Wigton have no further violations of the law, *i.e.*, violations of N.D.C.C. § 43-12.1-14 or N.D. Admin. Code § 54-02-07-01.1 as determined by the Board, during the period of two years from the date of the Board's order in this matter.

If Wigton is found by the Board to be in violation of N.D.C.C. § 43-12.1-14 or N.D. Admin. Code § 54-02-07-01.1 within the period of two years from the date of the issuance of the Board's order in this matter, Wigton's two year period of suspension for the violations proven in

this administrative action shall be invoked along with any suspension imposed as a result of further violations proven (revocation may be deemed appropriate for further violation).

Further, it is ORDERED that Wigton shall pay a penalty fee of $500 as a result of the violations proven in this matter, in a manner as the Board shall determine in a separate letter.

Further, it is ORDERED that Wigton shall pay to the Board all lawful costs and disbursements associated with this administrative matter as may be certified by the Executive Director of the Board, in a manner as may be determined by the Board in a separate letter.

Dated at Bismarck, North Dakota, this 19th day of February, 2002.

State of North Dakota
Board of Nursing

By: _____
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